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**BEFORE THE**
**BOARD OF VOCATIONAL NURSING AND PSYCHIATRIC TECHNICIANS**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against:<br><br>**MARICRIS VINGCO**<br>429 Nerdy Avenue<br>San Jose, California 95111<br><br>Vocational Nurse License No. VN 197472<br><br>Respondent. | Case No. VN-2003-1619<br><br>**ACCUSATION** |

Complainant alleges:

**PARTIES**

1. Teresa Bello-Jones, J.D., M.S.N., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Vocational Nursing and Psychiatric Technicians.

2. On or about December 4, 2001, the Board of Vocational Nursing and Psychiatric Technicians issued Vocational Nurse License Number VN 197472 to Maricris Vingco ("Respondent"). The Vocational Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on August 31, 2009, unless renewed.

**JURISDICTION**

3. This Accusation is brought before the Board of Vocational Nursing and Psychiatric Technicians ("Board"), under the authority of the following laws. All section

references are to the Business and Professions Code unless otherwise indicated.

## STATUTORY PROVISIONS

4. Section 2875 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline the holder of a vocational nurse license for any reason provided in Article 3 (commencing with section 2875) of the Vocational Nursing Practice Act.

5. Section 118(b) of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated. Under section 2892.1 of the Code, the Board may renew an expired license at any time within four years after the expiration.

6. Section 2878 of the Code states:

"The Board may suspend or revoke a license issued under this chapter [the Vocational Nursing Practice Act (Bus. & Prof. Code, 2840, et seq.)] for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual nursing functions.

. . . .

7. Title 16, California Code of Regulations, section 2519, states:

"As set forth in Section 2878 of the Code, gross negligence is deemed unprofessional conduct and is a ground for disciplinary action. As used in Section 2878 'gross negligence' means a substantial departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent licensed vocational nurse, and which has or could have resulted in harm to the consumer. An exercise of so slight a degree of care as to justify the belief that there was a conscious disregard or indifference for the health, safety, or welfare of the consumer shall be considered a substantial departure from the above standard of care."

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or

violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

## FACTUAL BACKGROUND

9. On or about February 12, 2002, an 89-year-old female resident ("Resident A") was admitted to Mission De La Casa Nursing Home in San Jose, California, a skilled nursing facility ("Mission De La Casa"), with diagnoses including stroke, dementia, and chronic renal insufficiency. On or about February 3, 2004, Resident A was prescribed a bolus feeding via a Nasogastric Tube (NGT).

10. On or about February 5, 2004, Respondent was on duty as a licensed vocational nurse at Mission De La Casa and was assigned to care for Resident A. Between the approximate time period of 8:00 a.m. and 9:00 a.m., Resident A removed her NGT. The NGT was reinserted by Janet Cabebe, R.N.

11. At approximately 12:00 p.m., Respondent administered a bolus feeding via the NGT. At approximately 12:30 p.m., one of Resident A's granddaughters observed that Resident A was spitting up clear saliva, became agitated, was coughing, had difficulty breathing, and complained of "hurting" from the NGT. Resident A asked to "stop the feeding."

12. At approximately 1:30 p.m., a second granddaughter observed that Resident A was agitated, hyperventilating, panicking, had a hard time breathing, her eyes were "wild" and "looking everywhere," she was upset, and she kept telling the nursing staff to "take the tube away."

13. At approximately 2:00 p.m., Janet Cabebe, R.N., examined Resident A's chest and stomach. Resident A's O2 saturation was 64%. The NGT feeding was discontinued. Resident A's primary care physician was notified, who ordered a transfer to the emergency room at Santa Clara Valley Medical Center ("VMC").

14. At approximately 3:00 p.m., Resident A was transported to VMC by a non-emergency ambulance. At the time of transfer, Resident A was in an altered state of consciousness, she had rapid, labored breathing at 28 respirations per minute, her pulse rate was 118 per minute, her systolic blood pressure was 172, with diastolic pressure detectable by

palpation.

15. On arrival at VMC, Resident A was in severe respiratory distress, with tachypnea, labored respirations, and in need of an immediate chest compression. A chest tube was inserted in her left pleural area, with 350cc drainage of enteral feeding-like fluid. An X-ray revealed a hydropneumothorax to Resident A's left lung.

16. Resident A was admitted to VMC with a diagnosis of pneumothorax secondary to tube feeding. Resident A died at approximately 11:25 p.m. on or about February 13, 2004.

## CAUSE FOR DISCIPLINE

**(Gross Negligence)**

17. Respondent is subject to disciplinary action under section 2761(a)(1) of the Code on the grounds of unprofessional conduct in that on or about February 5, 2004, while on duty as a licensed vocational nurse at Mission De La Casa, Respondent committed gross negligence, within the meaning of Title 16, California Code of Regulations section 2519, in her care of Resident A, in the following respects:

a. Respondent failed to ensure that the NGT was accurately and safely placed in Resident A's stomach prior to feeding Resident A through the NGT.

b. Respondent failed to recognize that the signs of severe agitation, coughing and restlessness were signs of acute respiratory distress.

c. Respondent failed to immediately remove the NGT after Resident A exhibited signs of acute respiratory distress.

d. Respondent failed to immediately notify a physician after Resident A exhibited signs of acute respiratory distress.

## PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Vocational Nursing and Psychiatric Technicians issue a decision:

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1. Revoking or suspending Vocational Nurse License Number VN 197472, issued to Maricris Vingco;

2. Ordering Maricris Vingco to pay the Board of Vocational Nursing and Psychiatric Technicians the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: January 4, 2008

TERESA BELLO-JONES, J.D., M.S.N., R.N.
Executive Officer
Board of Vocational Nursing and Psychiatric Technicians
State of California
Complainant